Rhode Island Accountable Entity Program

Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities:

Implementation Manual

Requirements for Program Years 1 through 4

Rhode Island Executive Office of Health and Human Services
January 21, 2021

A full revision history can be found at the end of the manual, before Appendix A.

Contents

Purpose

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality of care processes and outcomes.

The purpose of this document is to clearly outline guidelines for implementation of both the Total Cost of Care (TCOC) quality measures and P4P methodology and the Outcome measures and incentive methodology for Performance Years 1 through 4. The contents of this document supersede all prior communications on these topics.

	Program Year	TCOC Quality Measures Performance Year (QPY)	Outcome Measures Performance Year (OPY)
1	July 1, 2018-June 30, 2019	Jan 1, 2018-Dec 31, 2018	July 1, 2018-June 30, 2019
2	July 1, 2019-June 30, 2020	Jan 1, 2019-Dec 31, 2019	July 1, 2019-June 30, 2020
3	July 1, 2020-June 30, 2021	Jan 1, 2020-Dec 31, 2020	Jan 1, 2020-Dec 31, 2020
4	July 1, 2021-June 30, 2022	Jan 1, 2021-Dec 31, 2021	Jan 1, 2021-Dec 31, 2021

TCOC Quality Measures and P4P Methodology

AE Quality Measures

In accordance with 42 CFR §438.6(c)(2)(ii)(B)[1], AE quality performance must be measured and reported to EOHHS using the Medicaid Comprehensive AE Common Measure Slate. These measures shall be used to inform the distribution of any shared savings. For QPY1 and QPY2, AEs and MCOs could agree to include up to 4 additional optional menu measures.

The following table depicts the AE Common Measure Slate, required measure specifications, and whether the measure is pay-for-reporting (P4R), pay-for-performance (P4P), or reporting-only, by quality performance year. EOHHS expects that performance on each Common Measure Slate measure be reported annually for the full Quality Measures Performance Year.

Measures are categorized in the following ways:

- **P4R** status means that whether or not an AE reports the measure will influence the distribution of any shared savings.
- **P4P** status indicates that an AE's performance on the measure will influence the distribution of any shared savings.
- **P4R/P4P** indicates the measure may be utilized as either pay-for-reporting or pay-for-performance at the discretion of each contracting AE and MCO dyad.
- **Reporting-only** indicates that measure performance must be reported to EOHHS for EOHHS' monitoring purposes, but that there are no shared savings distribution consequences for submission or performance on the measure.

For QPY1 and QPY2, measures marked as P4R or P4P were required for incentive use.

For QPY3, measures were impacted by EOHHS's methodology changes outlined in the May 8, 2020 EOHHS memo "Program Year 2 and 3 Modifications to HSTP/AE program as a result of COVID 19." For QPY3, EOHHS required that all QPY3 AE Common Measure Slate measures be reported. However, only a subset of these measures had to be used in the incentive methodology (this is further outlined in Calculation of the Overall Quality Score below). In the table below, there are two columns for QPY3. "QPY3 Intended Incentive Use" indicates where QPY3 measure scores were intended to be used prior to the COVID-19 pandemic. In actuality, for QPY3, QPY2 measure categorization determined incentive use. "QPY3 Reporting" indicates the measures for which performance must be reported to EOHHS.

For QPY4, measures marked as P4R or P4P are once again required for incentive use. Of note, EOHHS is testing the Patient Engagement measure in 2020 and, if appropriate, may implement the measure as reporting-only for QPY4. A final decision on the measure status will be communicated later in 2020. See the May 26, 2020 EOHHS memo "Patient Engagement Measure Decision" for more information.

[1] https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

Measures[2]	Steward	Data Source[3]	Specifications	AE Common Measure Slate				
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use *and* QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo[4]	QPY3 Reporting	QPY4 Reporting and Incentive Use
HEDIS Measures								
Adult BMI Assessment	NCQA	Admin/Clinical	Current HEDIS specifications: QPY1: HEDIS 2019 QPY2: HEDIS 2020 QPY3: HEDIS MY 2020 QPY4: HEDIS MY 2021* *The AE/MCO Work Group will approve adoption of the HEDIS MY 2021 specifications when they are released in March 2021.	P4R	P4P/P4R			
Breast Cancer Screening	NCQA	Admin		P4R	P4P	P4P	Yes	P4P
Child and Adolescent Well-Care Visits (adolescent age stratifications only)[5]	NCQA	Admin				P4P	Yes	P4P
Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)	NCQA	Admin						Reporting-only
Comp. Diabetes Care: Eye Exam	NCQA	Admin/Clinical				P4P	Yes	P4P
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P	Yes	P4P
Controlling High Blood Pressure	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P	Yes	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4R – 7 or 30 days	P4P – 7 or 30 days	P4P – 7 days	Yes – 7 days	P4P – 7 days
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P	Yes	P4P
Non-HEDIS Measures (Externally Developed)								

[2] Attachments L1 for Program Years 1 and 2 included Self-Assessment/Rating of Health Status as developed by EOHHS. This measure is no longer part of the AE Common Measure Slate for QPY1-4. EOHHS communicated its decision to drop this measure from Program Year 2 in its 4/30/19 amended Attachment L1.

[3] "Admin/Clinical" indicates that the measure requires use of both administrative and clinical data.

[4] For QPY3, QPY2 measure categorization will be used for calculation of the QPY3 Overall Quality Score.

[5] EOHHS initially included the HEDIS "Adolescent Well-Care Visits" measure in the AE Common Measure Slate beginning in QPY3. NCQA modified the measure for MY2020 (which overlaps with QPY3) to combine the previous "Adolescent Well-Care Visits" measure and the "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life", include members age 7-11 and only allow reporting using administrative data rather than administrative data or hybrid data. EOHHS adopted the adolescent age stratifications of the new "Child and Adolescent Well-Care Visits" measure to align with the updated HEDIS measures and select a measure that was the closest replacement for the intended measure.

Measures[2]	Steward	Data Source[3]	Specifications	AE Common Measure Slate				
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use *and* QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo[4]	QPY3 Reporting	QPY4 Reporting and Incentive Use
Developmental Screening in the 1st Three Years of Life	OHSU	Admin/Clinical	QPY1-4: CTC-RI/OHIC (December 2018 version)[6]	P4R	P4P/P4R	P4P	Yes	P4P
Screening for Clinical Depression and Follow-up Plan	CMS	Admin/Clinical	QPY1: CMS MIPS 2018[7] QPY2: CMS MIPS 2019[8] QPY3: CMS MIPS 2020[9] QPY4: CMS MIPS 2021, September 15, 2020 version modified by EOHHS and included as Appendix A* *The AE/MCO Work Group will approve adoption of the CMS MIPS 2021 specifications when they are released in winter 2021.	P4R	P4P/P4R	P4R	Yes	P4P
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/Clinical	QPY1-4: CMS MIPS 2018[10]	P4R	P4P/P4R	Reporting-only	Yes	Reporting-only
Non-HEDIS Measures (EOHHS-developed)								
Social Determinants of Health Infrastructure Development	EOHHS	Admin/Clinical	QPY3-4: EOHHS (August 6, 2020 version – included as Appendix B)			P4P	Yes	
Social Determinants of Health Screening	EOHHS	Admin/Clinical	QPY1-2: EOHHS February 15, 2018 version[11] QPY3-4: EOHHS August 6, 2020 version – included as Appendix C	P4R	P4R	Reporting-only	Yes	P4P
Optional Measure Slates (for QPY1 and QPY2 EOHHS permits selection of up to 4 optional measures)[12]								

[6] http://www.ohic.ri.gov/documents/Revised-Measure-Specifications-Adult-and-Pedi-CTC-OHIC-Dec-2018-FINAL.pdf
[7] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures
[8] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures
[9] https://qpp.cms.gov/mips/explore-measures/quality-measures?tab=qualityMeasures&py=2020
[10] Tobacco Use: Screening and Cessation Intervention had substantive changes in the CMS MIPS 2019 version.
[11] http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf
[12] Optional Admin measures could be pay-for-performance in QPY1. Optional Admin/Clinical or Clinical-only measures could be pay-for-performance or pay-for-reporting in QPY1.

Measures[2]	Steward	Data Source[3]	Specifications	AE Common Measure Slate				
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use *and* QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo[4]	QPY3 Reporting	QPY4 Reporting and Incentive Use
OHIC Aligned Measure Set Menu			QPY1: OHIC 2018[13] QPY2: OHIC 2019[14]	P4R/P4P	P4R/P4P			
CMS Medicaid Adult Core Set			QPY1: CMS 2018[15] QPY2: CMS 2019[16]	P4R/P4P	P4R/P4P			
CMS Medicaid Child Core Set			QPY1: CMS 2018[17] QPY2: CMS 2019[18]	P4R/P4P	P4R/P4P			

[13] http://www.ohic.ri.gov/documents/Crosswalk%20of%20RI%20Aligned%20Measure%20Sets%202017%2011-2.xlsx
[14] http://www.ohic.ri.gov/documents/Crosswalk-of-RI-Aligned-Measure-Sets--For-2019-2018-10-13.xlsx
[15] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf
[16] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf
[17] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf
[18] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf

Eligible Population for All Measures

For QPY1 and QP2, all measures in the Common Measure Slate should be calculated with the Integrated Health Home (IHH) population attributed to the AE based on the member's behavioral health provider.

Beginning in QPY3, all measures in the Common Measure Slate should be calculated with IHH members attributed to the AE based on their primary care provider.

Beginning in QPY4, the eligible population should be calculated using the attribution methodology described in the "General Guidelines" section of the Implementation Manual.

Eligible Population for Non-HEDIS Measures

For QPY1 and QPY2, all non-HEDIS measures in the Common Measure Slate used the eligible population as defined in the measure's specification.

Beginning in QPY3, all non-HEDIS measures in the Common Measure Slate were defined to only include Active Patients in their denominator. Active Patients are individuals seen by a primary care clinician associated with the AE anytime within the last 12 months. For the purpose of these measures "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.

The following are the eligible visit codes for determining an Active Patient:

1. Eligible CPT/HCPCS office visit codes: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381–99387; 99391-99397; 99490; 99495-99496.
2. Eligible telephone visit, e-visit or virtual check-in codes:
    a. CPT/HCPCS/SNOMED codes: 98966-98968; 98969-98972; 99421-99423; 99441-99443; 99444; 11797002; 185317003; 314849005; 386472008; 386473003; 386479004.
    b. Any of the above CPT/HCPCS codes in 2.a. with the following POS codes: 02.
    c. Any of the above CPT/HCPCS codes in 2.a. with the following modifiers: 95; GT.

TCOC Quality P4P Methodology

This section describes the TCOC quality P4P methodology for QPY1-4. Medicaid AEs are eligible to share in earned savings based on a quality multiplier (the "Overall Quality Score"). Overall Quality Scores shall be generated for each AE based on the methodology defined below. The Overall Quality Score will be used as a multiplier to determine the percentage of the Shared Savings Pool the AE and MCO are eligible to receive. The Overall Quality Score shall function as a multiplier, and the TCOC quality P4P methodology does not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

Selection of P4P Measures

The table below outlines the required measures for the Overall Quality Score calculation, by year.

QPY	Minimum # P4P Measures	Specific Measures Required P4P
1	0	Any Optional Measure Slate measure using Admin data must be P4P
2	3	Breast Cancer Screening

QPY	Minimum # P4P Measures	Specific Measures Required P4P
		Follow-up after Hospitalization for Mental Illness (7 day or 30-day measure component)[19] One additional measure of choice from the AE Common Measure Slate or the Optional Measure Slates
3	3	P4P measures used in the QPY2 contracts
4	10	All AE Common Measure Slate measures except for Child and Adolescent Well-Care Visits (years 3-11 and total) and Tobacco Use: Screening and Cessation Intervention, as these are reporting-only measures.

Calculation of the Overall Quality Score

For QPYs 1 and 2, MCOs and AEs could use any EOHHS-approved methodology for calculating the Overall Quality Score. EOHHS approved these methodologies as part of its overall approval of TCOC contracts. EOHHS, has, however, provided a recommended methodology for MCO and AE use.[20] Even with this flexibility, EOHHS specifies the following stipulations:

- ***P4R Measures:*** EOHHS requires that any pay-for-reporting measures receive a pass/fail score (either 100% or 0%); there shall be no partial credit for reporting measures. The following conditions must be met to receive a passing score: 1) reporting of required data for the measure is timely and in accordance with MCO-defined formats; and 2) the process and methodology for calculating measure performance in accordance with the MCO-defined formats has been adequately demonstrated.
- **For QPY1**, All the Medicaid AE Common Measure Slate measures had to be included in the calculation of the Overall Quality Score.
- **For QPY2**, all measures had to be included in the Overall Quality Score, with a weight greater than 0% for each measure. The measure weight assigned to each measure was negotiable and had to be agreed upon by the MCO and AE. The Overall Quality Score had to be a sum of the measure- specific quality score times the measure weight for each measure.
- **For QPY3**, EOHHS modified the Overall Quality Score methodology that was documented in previous versions of this Implementation Manual in effort to hold providers harmless for QPY3 quality performance due to the COVID-19 pandemic. MCOs should use their existing QPY2 measures and methodology (inclusive of measure targets and weights), except that:
  1) for any measure designated as P4P in a QPY2 contract for which an AE's QPY3 value is superior to the QPY2 value, MCOs should use the QPY3 rate instead of the QPY2 rate in the calculation of the Overall Quality Score, and
  2) for Social Determinants of Health Screening, a QPY3 value may not be substituted for QPY2 since there were significant specification changes. Social Determinants of Health Screening is considered a reporting-only measure for QPY3.

[19] Note that while all measure subcomponents had to be reported, an individual measure subcomponent could be selected as having pay-for-performance status.

[20] See "Rhode Island Medicaid Accountable Entity Program, Attachment L 1 Accountability Entity Total Cost of Care Requirements – Program Year Two Requirements" December 11, 2018.

MCOs will be required to report measures that are in the QPY3 AE Common Measure Slate "Reporting" column to EOHHS, but unless the measure is listed as P4P in both "QPY2 Reporting and Incentive Use *and* QPY3 Incentive Use Per 5/8/20 EOHHS Memo" and "QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo", these measures will not be included in the Overall Quality Score calculation.

The Excel document "Example COVID 19 QPY3 Methodology 2020-5-12" illustrates the application of this modified QPY3 methodology. A copy of the document can be obtained through the embedded Excel document below or by emailing Rebekah LaFontant at EOHHS (Rebekah.LaFontant@ohhs.ri.gov). An example calculation can be found in **Appendix D: Example Overall Quality Score Calculation for QPY3**.

Example COVID19
QPY3 Methodology

In general, the following principles apply to the calculation of the QPY3 Overall Quality Score:

Measure Status in QPY2	Calculation of Measure Contribution to Overall Quality Score
P4P	• If the measure is: Adolescent Well-Care Visit, Breast Cancer Screening, Comprehensive Diabetes Care: HbA1c Control <8.0%, Controlling High Blood Pressure, Developmental Screening in the First Three Years of Life, Follow-up After Hospitalization for Mental Illness – 7 Days, Weight Assessment and Counseling for Children and Adolescents, or Screening for Depression and Follow-up plan – assess higher of QPY2 and QPY3 performance against the QPY2 targets to determine credit towards the Overall Quality Score • For any other P4P measure, assess QPY2 performance against the QPY2 target to determine credit towards the Overall Quality Score
P4R	Reporting of any performance rate in QPY2 will result in full credit towards the Overall Quality Score for QPY3
Not in QPY2	The measure should not be used in the calculation of the Overall Quality Score, but should be reported to EOHHS

For QPY4, EOHHS developed a standard Overall Quality Score methodology that is required for use by all AEs and MCOs. This is nearly the same methodology intended for QPY3 use before the onset of COVID-19. The required TCOC Overall Quality Score methodology is as follows:

1. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate P4P measure, except SDOH Screening, AEs will be

awarded whichever score yields the most performance points. The maximum earnable score for each measure will be "1", and each measure will be weighted equally.

a. Achievement targets:
    i. EOHHS will establish two achievement targets: "threshold" and "high-performance."
    ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
        1. If performance is below or equal to the threshold-performance target: 0 achievement points
        2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula:
            (Performance Score – Threshold Performance) / (High-Performance Target – Threshold Performance)
        3. If performance is equal to or above the high-performance target: 1 achievement point.

b. Improvement target:
    i. Improvement points will be awarded if QPY4 performance is 0.10 percentage points greater than baseline performance. AEs will not need to demonstrate a three-percentage point increase over baseline in QPY4, as the original QPY3 methodology specified.
        1. The value may be less than what would be required to demonstrate statistical significance in a given year.
    ii. QPY2 performance will be the basis of assessing improvement for QPY4, due to the anticipated negative impact of COVID-19 on QPY3 performance. EOHHS may revisit its selection of the baseline year in the first half of QPY4 after assessing early 2021 COVID-19 experience.
    iii. Improvement as defined by 1.b.i-ii will earn the AE a score of "1."

2. **Scoring SDOH Screening**: This measure will be scored differently than the other Common Measure Slate measures for QPY4. Given that this measure changed significantly in QPY3, there is no QPY2 rate against which EOHHS can assess improvement in QPY4. Therefore, AEs will only be assessed based on achievement for this measure in QPY4, as described in 1.a above.
3. **Overall Quality Score Calculation:** Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size (please see the section "Adequate Denominator Sizes" for the definition of adequate denominator size) and divide that sum by the number of measures for which there is an adequate denominator size. For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the ten measures and divide the result by 10.[21] This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score, adjusted upwards as described below, to determine the shared savings to be distributed to the AE. The MCO shall multiply the annual losses accrued by the AE by value of the Overall Quality Score divided by four, as described below, and subtract this product from the total

[21] Weight Assessment and Counseling for Children and Adolescents is assessed as one measure. The measure is a composite, created by averaging the scores of the three individual measure components 1) BMI percentile, 2) counseling for nutrition, and 3) counseling for physical activity.

losses to determine the shared losses to be paid by the AE. **Appendix E: Example Overall Quality Score Calculation for QPY4** illustrates this calculation.

a. Overall Quality Score Adjustment for Shared Savings Distribution**:** The overall quality multiplier shall be adjusted upwards by 0.10 for each AE contract, with a cap at one. This means, for example, that an AE earning 80% of the available points used to establish the quality multiplier would receive 90% of any earned shared savings.
b. Overall Quality Score Adjustment for Shared Losses Mitigation: The overall quality multiplier shall be divided by four for each AE contract to mitigate shared losses.

MCOs and AEs may calculate AE Overall Quality Score performance using the "Overall Quality Score Determinations" Excel model (current version: 1/7/2021). The "Overall Quality Score Determinations" Excel model can be obtained through the embedded Excel model below or by emailing Rebekah LaFontant at EOHHS (Rebekah.LaFontant@ohhs.ri.gov).

Overall Quality Score Determinatior

TCOC Quality Benchmarks

For QPY1 and QY2 benchmarks had to be negotiated by each AE and MCO dyad. These benchmarks were employed to evaluate AE performance on Common Measure Slate measures and optional measures to inform the negotiated formula for distribution of shared savings. For QPY2, AE and MCO dyads could modify the benchmark for Follow-up After Hospitalization for Mental Illness due to specification changes. AE and MCO dyads, however, had to take into consideration the change in national performance and adjusted the benchmark accordingly. For example, if national performance relative to a contractually referenced benchmark for the measure declined by 10%, it was reasonable for MCOs to reduce the contractual achievement benchmark by 10% as well. Additional information can be found in the September 25, 2020 "Summary of Final Decisions from the 2020 Meeting Series" memo.

For QPY3, negotiated AE and MCO QPY2 benchmarks shall be used to evaluate AE performance and inform the negotiated formula for distribution of shared savings. This includes the adjustment to the Follow-up After Hospitalization for Mental Illness measure described above.

For QPY4, EOHHS employed a combination of internal and external sources to set achievement targets. EOHHS set targets for Quality Performance Year 4 using AE Quality Performance Year 2 data,[22] national and New England Medicaid (HMO) data from NCQA Quality Compass 2020 (CY 2019), national and Rhode Island state FY 2019 data from CMS' 2019 Child and Adult Health Care Quality Measures report and Rhode Island practice-reported data for October 1, 2018 – September 30, 2019 from the Office of

[22] Quality Performance Year 2 data were submitted by MCOs by October 31, 2020. For ease of MCO reporting, MCOs had to submit data with the IHH population included.

the Health Insurance Commissioner (OHIC) Patient Centered Medical Home (PCMH) Measure Survey[23] in advance of Quality Performance Year 4. If there was a big drop in the number of AEs meeting the target when moving from one target source to another, EOHHS selected the easier-to-meet target.

EOHHS utilized AE Quality Performance Year 2 data to ensure the following guiding principles are met for the threshold target: 1) the threshold target should be below the current Rhode Island Medicaid plan-weighted average; the threshold target should be, if possible, roughly two percentile distributions lower than the current Rhode Island Medicaid plan-weighted average; and 3) the threshold target should never be below the Medicaid national 50th percentile. EOHHS also utilized the following guiding principles for the high-performance target: 1) the high-performance target should be attainable for at least some AEs; 2) the high-performance target should not exceed a value that represents a reasonable understanding of "high performance"; and 3) the high-performance target should ideally never be below the current performance of every single AE.

The achievement targets, set utilizing the data and guiding principles described above, for QPY4 are as follows:

Measure Name	Proposed Threshold Target	Source	Proposed High-Performance Target	Source
Breast Cancer Screening	61.8	NCQA National Medicaid 67th percentile	69.2	NCQA National Medicaid 90th percentile
Child and Adolescent Well-Care Visits (Adolescent Age Ranges Only)	52.8	NCQA National Medicaid 67th percentile, adjusted[24]	62.8	NCQA New England Medicaid 90th percentile, adjusted[25]
Comprehensive Diabetes Care: Eye Exam	61.6	NCQA National Medicaid 67th percentile	70.6	NCQA New England Medicaid 67th percentile
Comprehensive Diabetes Care: HbA1c Control <8.0%	51.7	NCQA National Medicaid 50th percentile	61.2	NCQA New England Medicaid 90th percentile
Controlling High Blood Pressure	61.8	NCQA National Medicaid 50th percentile	72.3	NCQA New England Medicaid 75th percentile
Developmental Screening in the First Three Years of Life	54.0	CMS National 75th percentile	65.8	CMS RI average

[23] The benchmarks were set using 2018-2019 OHIC performance instead of 2019-2020 performance due to the impact of COVID-19 on 2019-2020 performance. Further, the benchmarks were set using statewide practice rates rather than Medicaid-only practice rates because there were not enough data from Medicaid practices to obtain a statistically robust median rate.

[24] Source data were adjusted down nine percentage points to account for the difference moving from hybrid data to administrative data in QPY3 to align with changes in HEDIS specifications.

[25] See above footnote.

Measure Name	Proposed Threshold Target	Source	Proposed High-Performance Target	Source
Follow-up After Hospitalization for Mental Illness (7-day)	45.2	NCQA National Medicaid 67th percentile	64.9	NCQA National Medicaid 90th percentile
Screening for Clinical Depression and Follow-up Plan[26]	72.8 (*prior to adjustment*)	RI OHIC statewide 25th percentile	88.6 (*prior to adjustment*)	RI OHIC statewide 67th percentile
Social Determinants of Health (SDOH) Screen	25.0	N/A	50.0	N/A
Weight Assessment and Counseling for Children and Adolescents – Composite Score	74.5	NCQA National Medicaid 50th percentile	79.6	NCQA National Medicaid 67th percentile

Data Collection and Reporting Responsibilities

For QPY1 and QPY2, MCOs were responsible for reporting performance on all AE Common Measure Slate measures to EOHHS as well as any measures selected as pay-for-performance from the optional measure sets (i.e., the SIM Menu Measure Set and CMS Medicaid Child and Adult Core Sets) by September 30, 2019 and October 31, 2020, respectively. All Admin measures had to be generated and reported by the MCO. AEs had to provide the necessary data to the MCO to generate any Admin/Clinical measures. The MCO and AE had to agree upon the manner and format for demonstrating that appropriate measurement processes and methodologies are in place. For Admin/Clinical measures, this included: defining the clinical population and data sources, extracting data elements from the EHR, and reviewing data quality for accuracy and validity of measure scores. For the SDOH Screening measure, AEs had to demonstrate that processes were in place to administer the screening tool, and that data collection processes were aligned across the AE. EOHHS encouraged use of virtual record review of communication, as well as by fax and mail, where possible because of COVID-19.

For QPY3 and QPY4, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS by October 31 of 2021 and 2022, respectively. All Administrative measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities as described in the "Electronic Clinical Data Exchange" section below for Administrative/Clinical measures. Practices have varying capabilities for clinical data exchange so EOHHS will allow for AEs to exchange data via self-report (manual spreadsheet/file), but only if an AE lacks the capability for clinical data exchange as described below.

Electronic Clinical Data Exchange

EOHHS wishes to promote the capabilities of AEs to transmit clinical data to contracted MCOs. To assist in achieving that end, EOHHS offered incentive funding for AEs and MCOs during QPY2 for efforts to move towards electronic clinical data exchange for the Common Measure Slate for QPY3.

[26] The proposed targets for this measure need to be adjusted to account for the change in specifications for this measure beginning in QPY3, which specifies that a PHQ-9 score of 10+ is an indication for requiring follow-up.

EOHHS defines electronic exchange to be inclusive of any of the following methods:

1. aggregated AE-level file submitted to an MCO;
2. aggregated AE-level file submitted to the State's vendor, IMAT, which then submits data to an MCO;
3. individual practices within the AE submit data to an MCO, and
4. individual practices within the AE submit data to IMAT, which then submits data to an MCO.

For any of the options above, AEs must be able to submit data for those primary care practices together representing at least 75% of the AE's MCO-specific attributed lives for the exchange to be used for MCO generation of Common Measure Slate measures. If AEs are unable to electronically exchange clinical data for practices representing 75% or more of its MCO-specific attributed lives, MCOs must have received approval for an action plan and timeline for clinical data exchange readiness in 2019.

MCOs were required to submit an Operational Plan and Data Validation Plan to be eligible for QPY2 incentive funding. MCOs are required to submit **Implementation Status Reports** on an ongoing basis, which should detail the status of clinical data exchange efforts with *each* AE, including progress made since the last status report towards transmitting clinical data necessary to generate the AE Common Measure Slate measures, application of data validation activities, and identification of major issues that need to be resolved.

- Implementation Status Reports should be submitted using the standard template, included as **Appendix F: MCO Electronic Clinical Data Implementation Status Report Template**.
- Timing:
    - In the June 1, 2020 Implementation Status Reports, MCOs noted that clinical data exchanges will not be fully implemented until June 2021 due to COVID-19-related delays. Therefore, MCOs had to submit an additional Implementation Status Report to EOHHS by September 1, 2020 and shall submit another Report by March 15, 2021.

Finally, AEs and MCOs should **verify the accuracy of data reported using electronic clinical data exchange**. To achieve this, AEs must verify the integrity of a test submission of QPY2 clinical measure data with IMAT and UnitedHealthcare. Further, MCOs will need to report and assess any variation in reporting QPY3 performance using the clinical data exchange and the QPY1 and QPY2 reporting method.

- Timing:
    - AEs shall submit QPY2 clinical measure data to IMAT and UnitedHealthcare (per MCO clinical data exchange operational plans previously submitted to EOHHS) for testing purposes by July 1, 2021.[27]
    - IMAT and UnitedHealthcare shall verify the integrity of the test exchange of QPY2 clinical measure data from July 1, 2021 by August 1, 2021.
    - MCOs shall calculate and report AE performance on the Common Measure Slate for the QPY3 measures using (a) the clinical data exchange and (b) the QPY1 and QPY2 method by October 31, 2021.

[27] AEs will need to have fully validated their data and be in production by July 1, 2021 in order to submit QPY2 data at this time.

- MCOs shall analyze any systematic variation in performance between QPY3 data using (a) the clinical data exchange and (b) the QPY1 and QPY2 method by October 31, 2021. In QPY2 and QPY3, AEs will self-report positive results for all hybrid measures after MCOs identify all positive results from administrative data, including through clinical data exchange. MCOs will then compare the ratio of self-reported positives to administrative positives for each measure for QPY2 and QPY3, separating AEs with clinical data exchanges in place for QPY3 from those without. The changes in ratios for the AEs between QPY2 and QPY3 will identify the contributions of the clinical data exchange data. The ratios for AEs without clinical data exchanges in place will serve as a "control group." Of note, this assessment will allow AEs and MCOs to verify whether performance measures calculated following electronic clinical data exchange (and after undergoing several rounds of data validation conducted by AEs, MCOs and IMAT) have comparable results to those generated using the QPY1 and QPY2 reporting method. The assessment will be performed in parallel to the data validation performed by AEs, MCOs and IMAT as outlined in the AE-MCO clinical data exchange Evaluation Plans.

Outcome Measures and Incentive Methodology

The Medicaid Infrastructure Incentive Program (MIIP) runs through Program Years 1 through 4 (January 2018-June 2022) of the Accountable Entity program. Through the MIIP, AEs are eligible to receive funding from the Accountable Entity Incentive Pool (AEIP). One core determinant of funding eligibility is submission of and performance on a number of quality outcome metrics.

Outcome Measures

The table below depicts the Outcome Measures Slate, required measure specifications, and whether the measure is pay-for-reporting (P4R) or pay-for-performance (P4P) by Outcome Measure Performance Year. Performance on each measure must be assessed for the full Outcome Measures Performance Year.

Measures	Steward	Data Source	Specifications	Outcome Measures Slate			
				OPY1	OPY2	OPY3	OPY4
HEDIS Measures							
Ambulatory Care: Emergency Department	NCQA	Admin	OPY1: HEDIS 2019 or MCO-defined specifications OPY2: HEDIS 2020 or MCO-defined specifications	P4R	P4R		
Inpatient Utilization—General Hospital/Acute Care	NCQA	Admin		P4R	P4R		
All-Cause Readmissions	NCQA	Admin	OPY1: HEDIS 2019 or MCO-defined specifications OPY2: HEDIS 2020 or MCO-defined specifications OPY3: EOHHS – included as Appendix G OPY4: HEDIS MY 2020	P4R	P4R	Other*	P4P
Non-HEDIS Measures: Externally Developed							
Emergency Department Utilization for Individuals Experiencing Mental Illness	Oregon Health Authority	Admin	OPY3-4: EOHHS, adapted from OHA 2019[28] – included as Appendix H			Other*	P4P
Non-HEDIS Measures (EOHHS-developed)							
Potentially Avoidable ED Visits (in previous communications, this measure has been referred to as "Ambulatory Care-Sensitive ED Visits")	NYU, modified by EOHHS	Admin	OPY2-4: EOHHS – included as Appendix I		P4R	Other*	P4P

*Payment will be made for acceptable performance improvement plan submission and completion of a required presentation and question and answer exchange with EOHHS or its designee (see Calculation of the Outcome Measure Performance Area Milestones below).

[28] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Disparity-Measures-ED-Utilization-Among-Members-Experiencing-Mental-Illness.pdf

Eligible Population for Outcome Measures

Beginning in OPY3, all Outcome measures should be calculated with IHH members attributed to the AE based on their primary care provider.

Beginning in OPY4, the eligible population should be calculated using the attribution methodology described in the "General Guidelines" section of the Implementation Manual.

Outcome Measure Incentive Methodology

AEs must also demonstrate performance on Outcome measures.

Section of P4P Measures

The table below outlines the required reporting on Outcome measures.

OPY	Minimum # P4P Measures	Specific Measures Required P4P
1	0	
2	0	
3	0	
4	3	All Outcome Measure Slate measures

Calculation of the Outcome Measure Performance Area Milestones

For OPY 1: Performance was based on reporting of Outcome measures.

- MCOs had to calculate performance on the Outcome measures for each AE on a quarterly basis.
- AEs had to report to MCOs performance improvement plans specific to the outcome measures.
- The Outcome measures plan was due April 30, 2019.

For OPY2: Performance was based on reporting of Outcome measures.

- MCOs had to calculate performance on the Outcome measures for each AE on a quarterly basis to EOHHS for each AE.
- AEs had to provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits. AEs and MCOs had to meet to discuss these processes as well as performance on the OPY2 outcome metrics quarterly by October 31, 2019, January 31, 2020, April 30, 2020, and July 31, 2020.

For OPY3, AEs will earn a percentage of the AEIP based on the submission of an acceptable description and self-evaluation of implemented plans to improve performance on each of the three outcome measures and completion of a presentation and question-and-answer exchange with EOHHS or its designee. Specifically, AEs had to demonstrate *well-conceived, substantive and well-executed* efforts to improve performance in OPY3 for each of the three outcome measures. AEs were expected to work with MCOs to complete the required submissions and participate together in an interview with EOHHS to discuss Outcome performance improvement efforts. More information can be found in **Appendix J: Outcome Measure Reporting for PY3 Performance Improvement Plan Requirements and Templates**.

Action	Deadline	AE Incentive Pool Allocation
Submission of Outcome performance improvement reports	12/31/2020	Up to 15%

Action	Deadline	AE Incentive Pool Allocation
Interview with EOHHS to discuss Outcome performance improvement efforts	2/15/2021	Up to 20%

For OPY4, AEs will earn a percentage of the AEIP based on the annual performance on Outcome metrics. The Outcome metric score methodology is as follows:

1. **Target Structure:** AEs must demonstrate attainment of an achievement target. For each measure, an AE may earn either no credit or full credit.
2. **Measure Weights:** 45% of the AE Incentive Pool allocation and 45% of the MCO Incentive Management Pool allocation will be determined by Outcome measure performance. Weights to be applied to specific Outcome measures are provided in the table below. Should an AE not have an adequate denominator (as defined in "Adequate Denominator Sizes" below), the measure for which the denominator is too small will be dropped from the calculation and equal weight assigned to the remaining measure(s).

Outcome Measure	OPY4 Weight
All-Cause Readmissions	15%
Emergency Department Utilization for Individuals Experiencing Mental Illness	20%
Potentially Avoidable ED Visits	10%

Outcome Measure Targets

For OPY1, at least 50% of the performance goals on Outcome measures had to be based on reporting. Specifics were up to the negotiations of AE and MCO dyads.

For OPY2 EOHHS required that Outcome metrics be assessed on a pay-for-reporting basis.

For OPY3, EOHHS required submission of performance improvement plans for each of the three Outcome measures.

For OPY4, EOHHS will employ historical AE performance to set the achievement targets after Performance Year 2 data are available. EOHHS will rely on MCO-submitted data for QPY2 for All-Cause Readmission and on EOHHS-submitted data for Emergency Department Utilization for Individuals Experiencing Mental Illness and Potentially Avoidable ED Visits. It will share its proposed targets and rationale with the AE/MCO Work Group before finalizing the benchmarks by March 31, 2021.

Outcome Measures Data Collection Responsibilities

MCOs were responsible for reporting performance for each AE on all AE Outcome measures to EOHHS for OPY1 and OPY2. EOHHS shall generate AE Outcome measure performance rates for each AE for OPY3. For OPY4, EOHHS shall generate AE Outcome measure performance for each AE for all measures except for All-Cause Readmission, which will be generated by MCOs and reported to EOHHS for aggregation across MCOs. MCOs shall provide AEs with data necessary to help AEs perform well on the Outcome measures.

For OPY1, MCOs had to submit quarterly performance on the Outcome measures as part of the "AE Incentive Pool (AEIP) Milestones Template" as provided by EOHHS.

For OPY2, EOHHS had to assume responsibility for calculating AE Outcome measure performance, across MCOs. Final calculation of OPY performance will be calculated using 180 days of claims runout. MCOs had to provide AEs with data to assist in improvement on Outcome metrics. MCOs had to provide quarterly reports to the AEs on performance, by October 31, 2019, January 31, 2020, April 30, 2020, and July 31, 2020. MCOs had to also provide and patient lists to the AEs, as requested by AEs.

For OPY3, EOHHS assumed responsibility for calculating AE Outcome measure performance, across MCOs. Final calculation of OPY performance will be calculated using 180 days of claims runout. EOHHS shall provide semi-annual reports to AEs and MCOs by October 31, 2020 and January 31, 2021. It will report final performance to AEs and MCOs by July 31, 2021. MCOs had to continue to provide AEs with data to assist in improvement on Outcome metrics. MCOs had to provide quarterly reports to the AEs on performance by January 31, 2020, April 30, 2020, July 31, 2020 and October 31, 2020. MCOs had to also provide patient lists to the AEs, requested by AEs.

AEs were also required to submit performance improvement plans, as described in the Outcome Measure Incentive Methodology section above. AEs had to submit Outcome performance improvement reports by December 31, 2020 and participate in an interview together with MCOs and with EOHHS to discuss Outcome performance improvement efforts by February 15, 2021.

For OPY4, EOHHS shall assume responsibility for calculating AE Outcome measure performance, across MCOs, for Emergency Department Utilization for Individuals Experiencing Mental Illness and Potentially Avoidable ED Visits. It will calculate numerator and denominator performance using only the claims for the MCO to which the member is attributed. Final calculation of OPY performance will be calculated using 180 days of claims runout. EOHHS will report final performance (for financial incentives) to AEs and MCOs by July 31, 2022. MCOs will calculate AE-specific performance for the All-Cause Readmission measure and report performance to EOHHS by July 15, 2022 for aggregation across MCOs.

MCOs shall continue to provide AEs with data to assist in improvement on all three Outcome metrics. MCOs shall provide quarterly reports to the AEs and EOHHS on performance using three months of claims runout for a rolling 12-month period. MCOs are encouraged to provide subtotals for performance for the prior measurement period and the current measurement period. MCOs shall submit data for the reporting periods indicated in the table below by February 15, 2021, May 14, 2021, August 16, 2021 and November 15, 2021 using the "AEIP Quarterly Outcomes Metrics" template (current version: V4), which can be obtained through the embedded Excel model below or through the EOHHS SFTP site. MCOs shall also provide patient lists to the AEs, requested by AEs.

AEIPQuarterlyOutcomeMetricsPY4_REPO

Reporting Date	Reporting Period (Rolling 12-month Approach)
February 15, 2021	October 1, 2019 – September 30, 2020
May 14, 2021	January 1, 2020 - December 31, 2020
August 16, 2021	April 1, 2020 – March 31, 2021
November 15, 2021	July 1, 2020 – June 30, 2021

General Guidelines

This section contains some general guidelines that are applicable to both the TCOC Quality Measures and P4P Methodology and the Outcome measures and Incentive Methodology.

Patient Attribution to AEs

Beginning for PY4, for purposes of evaluating annual Quality and Outcome measure performance , each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for measurement purposes. EOHHS and MCOs shall determine attribution using the AE provider rosters that are in place as of December of the performance year.

For purposes of evaluating quarterly Outcome measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in the last month of each quarter, i.e., March, June, September and December of the performance year. If a member is not enrolled in the last month of each quarter, the member will not be attributed to any AE for measurement purposes for that quarterly report. MCOs shall determine attribution using the AE provider rosters that are in place as of the last month of each quarter of the performance year.

Provider Attribution to AEs

Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."

Changes to Specifications

EOHHS shall annually convene AEs and MCOs to review whether annual measure specification changes are substantive. If changes are substantive, the work group will make recommendations to EOHHS on how to handle the measure during the year of the substantive change. If changes are not substantive, MCOs shall be granted flexibility to calculate the measure using the new or old specifications for the year in which the changes have been adopted.

In July 2020, NCQA published HEDIS changes for both HEDIS MY 2020 and HEDIS MY 2021. NCQA did so to transition from its prior process of releasing measure specification changes during the performance year to its new process of releasing measure specification changes in advance of the performance year. During the 2020 annual review, EOHHS asked AEs and MCOs to review HEDIS changes and non-HEDIS changes for Quality and Outcome Performance Years 3 and 4. AEs and MCOs will finalize changes for Quality and Outcome Performance Year 4 after NCQA releases its Technical Specifications Update for MY 2021 on March 31, 2021.

During the 2021 annual review, EOHHS will ask AEs and MCOs to review HEDIS changes (released on August 1, 2021) and non-HEDIS changes for Quality and Outcome Performance Year 5. AEs and MCOs will finalize changes for Quality and Outcome Performance Year 5 after NCQA releases its Technical Specifications Update for MY 2022 on March 31, 2022.

Adequate Denominator Sizes

There must be an adequate denominator size at the AE and MCO dyad level for a P4P measure to be included in the TCOC Quality measure performance calculations. Consistent with NCQA guidelines per the HEDIS® MY 2020 and MY 2021 Volume 2: Technical Update, minimum denominator sizes are defined as follows:

Measure Type	Measures	Minimum Denominator Size
Quality Measures	• AE Common Measure Slate •	30
Utilization Measures	• Potentially Avoidable ED Visits • Emergency Department Utilization for Individuals Experiencing Mental Illness • All-Cause Readmissions	360 member months

TCOC Quality and Outcome Measures Reporting Timeline

The table below indicates regular reporting activity responsibilities of EOHHS, AEs, and MCOs specific to the TCOC Quality Measures and Outcome Measures Slate.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	1/31/2020
Outcomes	Outcome performance reporting	Second quarter reporting of OPY2 performance and first quarterly reporting of OPY3 performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs[29]	MCOs	OPY2/3	1/31/2020
TCOC	Clinical data exchange	Submission of clinical data exchange revised Operational and Data Validation Plans	MCOs	QPY2	2/3/2020
TCOC	Clinical data exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	4/1/2020
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	4/30/2020
Outcomes	Outcome performance reporting	Third quarter reporting of OPY2 performance and second quarter reporting of OPY3 performance on the Outcome measures for a	MCOs	OPY2/3	4/30/2020

[29] One report will serve for both Outcome performance years due to the overlapping performance periods.

Topic	Category	Task	Responsible Party	PY	Deadline
		rolling 12 months of performance to AEs and patient lists as requested by the AEs[30]			
TCOC	Patient engagement	Determination of whether EOHHS will provide the measure code to MCOs	EOHHS	QPY3	6/1/2020
TCOC	Clinical data exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	6/1/2020
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	7/31/2020
Outcomes	Outcome performance reporting	Fourth quarter reporting of OPY2 performance and third quarterly reporting of OPY3 performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs[31]	MCOs	OPY2/3	7/31/2020
Outcomes/TCOC	Updates to measure specifications and measure methodology changes	Annual convening of AE/MCO participants to discuss: 1) Approve adoption of updated measure specifications for use in OPY3, QPY3, OPY4, and QPY4. Of note, HEDIS is transitioning to a prospective release of updates. July 1, 2020 both HEDIS 2020 and HEDIS 2021 updates will be available.[32] 2) any changes to the measures or methodology for OPY4 and QPY4	EOHHS	OPY4/QPY4	7/31/2020

[30] One report will serve for both Outcome performance years due to the overlapping performance periods.
[31] One report will serve for both Outcome performance years due to the overlapping performance periods.
[32] Following 2020, HEDIS updates will become available August 1 prior to the HEDIS measurement year.

Topic	Category	Task	Responsible Party	PY	Deadline
TCOC	Clinical data exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	9/1/2020
TCOC	Patient engagement	Piloting of the measure by one or more MCOs in coordination with EOHHS	MCOs/EOHHS	QPY3	9/30/2020
TCOC	Common Measure Slate performance reporting	Calculation and reporting of AE performance on the Common Measure Slate to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY2	10/31/2020
Outcomes	Outcome performance reporting	EOHHS provides first semi-annual OPY3 measure performance report to AEs.	EOHHS	OPY3	10/31/2020
Outcomes	Outcome performance reporting	Fourth quarter reporting of OPY3 performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs	MCOs	OPY3	10/31/2020
TCOC	Overall Quality Score methodology	Calculation of threshold, high-achievement and improvement targets for QPY4	EOHHS	QPY4	12/31/2020
Outcomes	Outcome performance reporting (for financial incentives)	Submission of Outcome performance improvement reports	AEs	OPY3	12/31/2020
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs	EOHHS	OPY2	1/28/2021

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting	EOHHS provides second semi-annual OPY3 measure performance report to AEs	EOHHS	OPY3	1/31/2021
Outcomes	Outcome performance reporting	First quarterly report of Outcome measure performance for OPY4 for the October 1, 2019 to September 30, 2020 reporting period due to AEs and EOHHS; reporting of patient lists, as requested by the AEs, due to AEs	MCOs	OPY4	2/15/2021
TCOC	Patient engagement	Review of pilot results by Patient Engagement Work Group	MCOs/EOHHS	OPY3	1/31/2021
Outcomes	Outcome performance reporting (for financial incentives)	Participation in an interview with EOHHS to discuss Outcome performance improvement efforts	AEs/MCOs	OPY3	2/15/2021
TCOC	Patient engagement	Determination of whether EOHHS will continue to use the specifications or modify the specification as needed	EOHHS	QPY3	2/28/2021
TCOC	Clinical data exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY3	3/15/2021
Outcomes	Outcome measure scoring methodology	Calculation of achievement targets for OPY4	EOHHS	OPY4	3/31/2021
Outcomes/TCOC	Updates to measure specifications and measure and methodology changes	Annual convening of AE/MCO participants to: 1) approve adoption of updated measure specifications for use in OPY4 and QPY4[33], 2) approve adoption of updated measure specifications for use in OPY5 and QPY5[34] and 3) discuss any changes to the measures or methodology for OPY5 and QPY5.	EOHHS	OPY4/ QPY4	3/2021 – 8/2021

[33] HEDIS MY 2021 specifications will become available in March 2021. CMS MIPS 2021 specifications will become available in winter 2021.
[34] HEDIS MY 2022 specifications will become available August 1, 2021.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting	Second quarterly report of Outcome measure performance for OPY4 for the January 1, 2020 to December 31, 2020 reporting period due to AEs and EOHHS; reporting of patient lists, as requested by the AEs, due to AEs	MCOs	OPY4	5/14/2021
TCOC	Clinical data exchange	Submission of QPY2 clinical measure data to IMAT and UnitedHealthcare, per MCO clinical data exchange operational plans previously submitted to EOHHS, for testing purposes (Note: AEs will need to have fully validated their data and be in production by 7/1/2021 in order to submit QPY2 data at this time)	AEs	QPY2	7/1/2021
Outcomes	Outcome performance reporting	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY3	7/30/2021
Outcomes	Outcome performance reporting	Third quarterly report of Outcome measure performance for OPY4 for the April 1, 2020 to March 31, 2021 reporting period due to AEs and EOHHS; reporting of patient lists, as requested by the AEs, due to AEs	MCOs	OPY4	8/16/2021
TCOC	Clinical data exchange	IMAT and UnitedHealthcare verify the integrity of the test exchange of QPY2 clinical measure data from July 1, 2021	IMAT/ UnitedHealthcare	QPY2	8/1/2021
TCOC	Common Measure Slate performance reporting	Calculation and reporting of AE performance on the Common Measure Slate for QPY3 measures using (a) the clinical data exchange and (b) the QPY1 and QPY2 method to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY3	10/31/2021
Outcomes	Outcome performance reporting	Fourth quarterly report of Outcome measure performance for OPY4 for the July 1, 2020 to	MCOs	OPY4	11/15/2021

Topic	Category	Task	Responsible Party	PY	Deadline
		June 30, 2021 reporting period due to AEs and EOHHS; reporting of patient lists, as requested by the AEs, due to AEs			
TCOC	Overall Quality Score methodology	Analysis of any systematic variation in performance between QPY2 and QPY3 data using (a) the clinical data exchange and (b) the QPY1 and QPY2 method; if there is a systematic difference, change threshold and high-achievement targets as appropriate for QPY4	EOHHS	QPY3	10/31/2021
TCOC	Overall Quality Score and Outcome measure scoring methodology	Calculation of threshold, high-achievement and improvement targets for QPY5 and OPY5 using QPY1-3 and other available data	EOHHS	OPY5/ QPY5	12/31/2021
Outcomes	Outcome performance reporting	Reporting of final AE-specific performance on All-Cause Readmission to EOHHS for aggregation across MCOs	MCOs	OPY4	7/15/2022
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY4	7/31/2022
TCOC	Common Measure Slate and Outcome Measure Slate performance reporting	Calculation and reporting of AE performance on the Common Measure Slate to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY4	10/31/2022

Revision History

Version	Date	Revisions
1.0	4/26/19	Initial version of implementation manual
1.1	7/17/19	Updated to include SDOH measure specifications, added TCOC P4P methodology, revised TCOC reporting requirements, revised information on clinical data exchange, revised TCOC measure reporting timeline, added outcome measures methodology and reporting requirements, revised outcome measures timeline and other smaller edits.
1.2	8/1/19	Updated to remove embedded documents except where indicated (instead included as appendices), added in information about the calculation of the Weight Assessment and Counseling for Children and Adolescents composite measure, refined the SDOH Infrastructure Development specifications, merged TCOC and Outcome timelines into a single chronological timeline, added instructions on the submission of the Operational and Data Validation Plans, extended the due date for the requirement for AEs and MCOs to meet to discuss OPY2 processes to reduce avoidable IP admissions and ED visits and other smaller edits.
1.3	10/10/19	Updated to change Screening for Clinical Depression and Follow-up Plan to P4R for QPY3, remove the reporting-only Patient Engagement measure for QPY3, add language noting the intent of EOHHS to share MCO-submitted clinical data exchange reports with the AEs, remove reference to the overall quality score applying to shared losses, revise the timing and benchmark sources for the QPY3 TCOC Quality Benchmarks, revise the specifications allowed for use in OPY1 and OPY2, update the OPY3 Outcome Measure Targets to change Coastal's target for Potentially Avoidable ED Visits and add All-Cause Readmissions targets, add outcome measure weights, add Appendix D "Example Overall Quality Score Calculation for QPY3," add Appendix G "All-Cause Readmissions," and other smaller edits.
1.4	12/11/19	Revised timeline for MCO calculation of baseline QPY2 performance on the Common Measure Slate using clinical data, timeline for EOHHS to provide final quality targets for QPY3, updated requirement for OPY2 to clarify documentation must be provided on inpatient admissions instead of avoidable inpatient admissions, removed EOHHS re-assessment of OPY3 benchmarks based on OPY2 data, changed timeline for EOHHS re-assessment of the OPY3 benchmark for Emergency Department Utilization for Individuals Experiencing Mental Illness, clarified the CPT codes under "Eligible Population for Non-HEDIS Measures" are used to define Active Patient, clarified that performance above or equal to the high achievement target will result in full credit under the TCOC methodology, clarified that both QPY1 and QPY2 data will inform the final TCOC QPY3 targets, changed CDE requirements from 90% to 75% of attributed lives and other smaller edits.
1.5	3/13/20	Revised the methodology used to set interim QPY3 targets to reflect methodology stated in the 11/26/19 memo, added language on the level of quality performance needed to achieve full shared savings distribution as stated in the 11/26/19 memo, updated clinical data exchange

Version	Date	Revisions
		deadlines based on changes to deliverables, updating timing for reporting on the AE Common Measure Slate, clarified timing of Outcome quarterly reports and other smaller edits.
1.6	5/13/20	Revised QPY2, QPY3, and OPY3 sections to reflect the May 8, 2020 EOHHS memorandum "Program Year 2 and 3 Modifications to HSTP/AE program as a result of COVID 19."
2.1	10/7/20	Updated to include QPY4 and OPY4 methodology (including Appendix E "Example Overall Quality Score Calculation for QPY4"), revised electronic clinical data exchange timelines (which are delayed due to COVID-19), incorporated decisions recommended during the 2020 AE and MCO Work Group discussions, included specifications for non-HEDIS measures (i.e., Screening for Clinical Depression and Follow-up Plan and Emergency Department Utilization for Individuals with Mental Illness), revised specifications for non-HEDIS measures to incorporate telehealth (i.e., SDOH Screening, SDOH Infrastructure Development and Screening for Clinical Depression and Follow-up Plan), added the SQL code utilized by EOHHS to calculate the Outcome measures and other smaller edits
2.2	1/21/2021	Updated to include minor clarifications necessary as a result of public comment, embed a revised version of the "Overall Quality Score Determinations" Excel model, include new QPY4 targets and a revised QPY4 methodology, clarify attribution requirements for Quality and Outcome measures, revise the requirements for interim Outcome measure reporting, embed the "AEIP Quarterly Outcome Metrics" template, specify how EOHHS is calculating performance for Emergency Department Utilization for Mental Illness, include revised SQL code utilized by EOHHS to calculate performance for two Outcome measures and other smaller edits.

Appendix A: Screening for Clinical Depression and Follow-up Plan

Screening for Clinical Depression and Follow-up Plan
Steward: Centers for Medicare and Medicaid Services Merit-based Incentive Payment System 2020, Modified by Rhode Island Executive Office of Health and Human Services
As of December 8, 2020

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- This measure has been modified for reporting in QPY4 to specify that *for the purpose of this measure* a PHQ-9 score of 10+ is an indication of a positive screen and needed follow-up.

Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Definitions

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of screenings tools include but are not limited to those provided in the three rows below.
Adolescent Screening Tools (12-17 Years)	Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
Adult Screening Tools (18 Years and Older)	Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale or Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
Perinatal Screening Tools	Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating

	Depression Scale
Follow-up Plan	Documented follow-up for a positive depression screening ***must*** include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Examples of a follow-up plan include but are not limited to: • Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder • Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale • Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression • Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options • Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	Ages 12 and older
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Event/diagnosis	Patient has at least one eligible encounter during the measurement period

Exclusions	Patients with an active diagnosis for depression or a diagnosis of bipolar disorder
Exceptions	• Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g., certain court appointed cases or delirium)

Administrative Specification[35]

Denominator	The eligible population 1. Patients aged ≥12 years on date of encounter AND 2. Patient encounter during the performance period: a. Eligible CPT/HCPCS office visit codes: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381–99387; 99391-99397; 99490; 99495-99496 b. Eligible telephone visit, e-visit or virtual check-in codes: i. CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ii. Any of the above CPT/HCPCS codes in 2.a. with the following POS codes: 02 iii. Any of the above CPT/HCPCS codes in 2.a. with the following modifiers: 95, GT AND NOT 3. Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required: G9717 AND NOT 4. Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) – a. Patient has an active diagnosis of depression prior to any encounter during the measurement period - F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345 b. Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period - F31.10,

[35] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_134_MIPSCQM.pdf.

	F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9 AND NOT 5. Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period: a. Patient refuses to participate b. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status c. Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter 1. Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented (G8431) OR 2. Performance Met: Screening for depression is documented as negative, a follow-up plan is not required (G8510) OR 3. Denominator Exception: Screening for depression not completed, documented reason (G8433) OR 4. Performance Not Met: Depression screening not documented, reason not given (G8432) OR 5. Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given (G8511) **Note**: A PHQ-9 score of 10+ is an indication of a positive screen and needed follow-up for the purpose of this measure.

Clinical Specification[36]

Denominator	The eligible population
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is

[36] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2020_Measure_PREV12_CMSWebInterface_v4.1.pdf.

	documented on the date of the eligible encounter **Note**: A PHQ-9 score of 10 is an indication of a positive screen and needed follow-up for the purpose of this measure.

Appendix B: SDOH Infrastructure Development Measure Specifications

Social Determinants of Health (SDOH) Infrastructure Development
Steward: Rhode Island Executive Office of Health and Human Services
As of August 6, 2020

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[37]

The percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical

Event/diagnosis	• The patient has been seen by an AE-affiliated primary care clinician anytime within the last 12 months
	• For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.
	• Follow the below to determine a primary care visit:
	  ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496
	  ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit:
	  ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005,

[37] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

	386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	N/A

Electronic Data Specifications

The percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed.

Denominator	The eligible population
Numerator	Individuals attributed whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed as of 12/31/20.
Unit of measurement	N/A
Documentation requirements	N/A
Approved screening tools	N/A
Required domains	N/A

Appendix C: SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of August 6, 2020

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[38]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical

Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months
	• For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.
	• Follow the below to determine a primary care visit:
	  ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496
	  ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit:
	  ▪ CPT/HCPCS/SNOMED codes: 98966-98968,

[38] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

	98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.

Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Appendix D: Example Overall Quality Score Calculation for QPY3

Below is a high-level example of the calculation of the Overall Quality Score for QPY3. A more detailed example on the calculation of the individual score components can be found in the "Example COVID 19 QPY3 Methodology 2020-5-12" Excel model. The Excel model can be obtained through the embedded Excel document model below or by emailing Rebekah LaFontant at EOHHS (Rebekah.LaFontant@ohhs.ri.gov).

Example COVID19 QPY3 Methodology

It is important to note, that for QPY3, the Overall Quality Score should be calculated using the MCO's QPY2 methodology, inclusive of measure categorization determinations, targets, and weights. The only distinction is if a measure if P4P in QPY2, and the measure remains in the AE Common Measure Slate for QPY3 as P4P, then a QPY3 superior rate may be substituted for the QPY2 rate. The example below is for illustrative purposes only.

Measure	Status in QPY2 Contract	Previously Intended Status in QPY3	QPY2 Mid-Target (worth 75% of points)	QPY2 High-Target (worth 100% of points)	QPY2 Performance	QPY3 Performance	QPY3 Measure Score	QPY2 Measure Weight	Principle Applied for QPY3 Score
Adult BMI Assessment	P4R	N/A	65%	70%	45%		1.00	5%	Use QPY2 P4R submission
Adolescent Well-Care Visit	N/A	P4P	70%	80%		83%	N/A		Not in QPY2 contract, do not use
Breast Cancer Screening	P4P	P4P	65%	70%	67%	55%	0.75	15%	Use QPY2 performance because higher than QPY3
Comprehensive Diabetes Care: Eye Exam	N/A	P4P	70%	80%		82%	N/A		Not in QPY2 contract, do not use

Measure	Status in QPY2 Contract	Previously Intended Status in QPY3	QPY2 Mid-Target (worth 75% of points)	QPY2 High-Target (worth 100% of points)	QPY2 Performance	QPY3 Performance	QPY3 Measure Score	QPY2 Measure Weight	Principle Applied for QPY3 Score
Comprehensive Diabetes Care: HbA1c Control <8.0%	P4R	P4P	65%	70%	62%	60%	1.00	5%	Use QPY2 P4R submission
Controlling High Blood Pressure	P4P	P4P	70%	80%	65%	80%	1.00	5%	Use QPY3 performance because higher than QPY2
Developmental Screening in the First Three Years of Life	P4R	P4P	65%	70%	90%	85%	1.00	5%	Use QPY2 P4R submission
Follow-up After Hospitalization for Mental Illness (7-day)	P4P	P4P	70%	80%	40%	50%	0.00	15%	Use QPY3 performance because higher than QPY2, still too low to qualify for incentive
Follow-up After Hospitalization for Mental Illness (30-day)	N/A	N/A	65%	70%			N/A		Not in QPY2 contract, do not use
Weight Assessment and Counseling for Children and Adolescents - Composite Score	P4P	P4P	70%	80%	40%	50%	0.00	15%	Use QPY3 performance because higher than QPY2, still too low to qualify for incentive

Measure	Status in QPY2 Contract	Previously Intended Status in QPY3	QPY2 Mid-Target (worth 75% of points)	QPY2 High-Target (worth 100% of points)	QPY2 Performance	QPY3 Performance	QPY3 Measure Score	QPY2 Measure Weight	Principle Applied for QPY3 Score
Screening for Clinical Depression & Follow-up Plan	P4R	P4R	65%	70%	60%	65%	1.00	5%	Use QPY2 P4R submission
Social Determinants of Health Screening	P4R	Reporting-only	70%	80%	50%	50%	1.00	5%	Use QPY2 P4R submission
Social Determinants of Health Infrastructure Development	N/A	P4P	70%	80%		100%	N/A		Not in QPY2 contract, do not use
Tobacco Use: Screening and Cessation Intervention	P4R	Reporting-only	65%	70%	65%	65%	1.00	5%	Use QPY2 P4R submission
Measure selected from the Optional Measure Slates for QPY2 Incentive Use	P4R	N/A	70%	80%	70%		1.00	5%	Use QPY2 P4R submission
Measure selected from the Optional Measure Slates for QPY2 Incentive Use	P4R	N/A	65%	70%	52%		1.00	5%	Use QPY2 P4R submission
Measure selected from the Optional Measure Slates for QPY2 Incentive Use	P4R	N/A	70%	80%	78%		1.00	5%	Use QPY2 P4R submission
Measure selected from the Optional Measure Slates for QPY2 Incentive Use	P4R	N/A	70%	80%	75%		1.00	5%	Use QPY2 P4R submission
OVERALL QUALITY SCORE FOR QPY3								**0.66**	

Appendix E: Example Overall Quality Score Calculation for QPY4

Below is a high-level example of the calculation of the Overall Quality Score for QPY4. Further information on calculation of the individual score components can be found in the "Overall Quality Score Determinations" Excel model (current version: 1/7/2021). The "Overall Quality Score Determinations" Excel model can be obtained by through the embedded Excel model below or emailing Rebekah LaFontant at EOHHS (Rebekah.LaFontant@ohhs.ri.gov).

Overall Quality Score Determinatior

Cells in grey indicate the target type is not applicable for a given measure in QPY4.

Measure	Score by Target Type			Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 1)	Reporting (0 or 1)	
Breast Cancer Screening	1	1		1
Child and Adolescent Well-Care Visit (adolescent age stratifications only)	1	0		1
Comprehensive Diabetes Care: Eye Exam	0.65	0		0.65
Comprehensive Diabetes Care: HbA1c Control <8.0%	0	1		1
Controlling High Blood Pressure	0.70	1		1
Developmental Screening in the First Three Years of Life	0	0		0
Follow-up After Hospitalization for Mental Illness (7-day)	0.45	1		1
Weight Assessment and Counseling for Children and Adolescents - Composite Score	0.30	0		0.30
Screening for Clinical Depression & Follow-up Plan	0.80	1		1
Social Determinants of Health Screening	1			1
Overall Quality Score (sum of final measure scores divided by number of measures)				=7.95/10 **= 0.795**
Overall Quality Score Adjustment (upwards adjustment of 0.10 with a cap of 1) for Shared Savings Distribution				=0.795+0.1=**0.895**
Overall Quality Score Adjustment (Quality Score divided by 4) for Shared Losses Mitigation				=0.795/2=**0.398**

Appendix F: MCO Electronic Clinical Data Implementation Status Report Template

The template below should be used by MCOs for submission of electronic clinical data exchange Implementation Status Reports.

Reports should be sent to EOHHS following the EOHHS Medicaid MCO Requirements for Reporting and Reporting Penalties Policy and Procedures for Managed Care Core Contact (embedded below) by March 15, 2021.

Report Information

MCO:

Report Submitter:

Reporting Period:

Operational Considerations

Please describe the status of your clinical data collection efforts with each contracted AE. All responses should include a description of the following activity, with associated timelines for each:

1. the planned data exchange methodology;
2. the status of process planning to exchange data (if not already initiated);
3. the plan for test data transmission and measure calculation activity;
4. identification of data transmission issues, and
5. proposed next steps to resolve data transmission issues.

BVCHC:

Coastal:

IHP:

Integra:

PCHC:

Prospect:

If you previously received any feedback from EOHHS on your Operational Plan, please describe steps taken to address EOHHS' feedback:

Data Validation

Please describe the status of your data validation activities with each contracted AE. Narrative descriptions should touch on the following activity, with associated timelines for each:

1. assessment and data profiling of AE files for quality;
2. reconciliation of issues identified by the initial file review;
3. incorporation of external data validation and audit processes to ensure data accuracy;
4. management of the merging of AE and MCO data, and
5. calculation of valid clinical measure rates.

BVCHC:

Coastal:

IHP:

Integra:

PCHC:

Prospect:

If you previously received any feedback from EOHHS on your Data Validation Plan, please describe steps taken to address EOHHS' feedback:

Appendix G: All-Cause Readmissions

All-Cause Readmissions
Steward: Rhode Island Executive Office of Health and Human Services
As of August 7, 2020

Description

For members 18 years of age and older, the number of inpatient stays during the measurement year that were followed by an unplanned readmission for any diagnosis within 30 days of discharge. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of Observed 30-Day Readmissions (numerator).

Definitions

IHS	Index hospital stay. An inpatient stay with admission on or between January 1 and December 31 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date. The index admission date must occur on or between January 1 and December 31 of the measurement year.
Index Discharge Date	The IHS discharge date.
Index Readmission Stay	An inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the *numerator*.
Plan population	Members who are 18 and older as of the date of index admission. Assign members to the MCO and AE at the time of index admission.

Eligible Population

Product line	Medicaid
Stratification	N/A
Ages	Ages 18+ as of the index admission date
Continuous enrollment	None
Allowable gap	None
Anchor date	Index admission date
Event/diagnosis	An inpatient stay admission on or between January 1 and December 31 of the measurement year. The denominator for this measure is based on admissions, not members.

Follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator Inpatient stays among the eligible population.

Step 1 Identify all inpatient stays with an admission date on or between January 1 and December 1 of the measurement year. To identify inpatient admissions:

1. Identify all inpatient stays.
2. Identify the admission and discharge date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

The measure includes discharges from any type of facility (including behavioral healthcare facilities). Residential substance abuse treatment programs are not considered inpatient stays and should not be included in the measure.

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Step 3 Exclude hospital stays with any of the following criteria on the discharge claim:

- Maternity (neonate) stays.
- Admissions using any of the following:
    - A principal diagnosis of cancer chemotherapy.
    - A principal diagnosis of radiation therapy.
    - A principal diagnosis of hemodialysis.

Numerator Readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all inpatient stays with an admission date on or between January 1 and December 31 of the measurement year. To identify inpatient admissions:

1. Identify all inpatient stays.
2. Identify the admission and discharge dates for the stay.

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge date.

Step 3 Exclude hospitalizations with any of the following criteria on the discharge claim:

- Maternity (neonate) stays.
- Admissions using any of the following:
    - A principal diagnosis of cancer chemotherapy.
    - A principal diagnosis of radiation therapy.
    - A principal diagnosis of hemodialysis.

Step 4 For each IHS identified in the denominator, determine if any of the inpatient stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Reporting: Denominator

Count the number of IHS among Medicaid members for each reporting year, stratified by MCO and AE at time of IHS.

Reporting: Numerator

Count the number of observed IHS among Medicaid members with a readmission within 30 days of discharge for each reporting year, stratified by MCO and AE at time of IHS.

Calculated: **Readmission Rate**

The count of observed 30-day readmissions divided by the count of index stays, stratified by MCO and AE at time of IHS.

Oracle SQL Code Used by EOHHS

All-Cause
Readmissions EOHH

Appendix H: Emergency Department Utilization for Individuals Experiencing Mental Illness

Steward: Oregon Health Authority, January 29, 2020 Specifications, Adapted by Executive Office of Health and Human Services
As of January 5, 2021

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- These are the specifications that EOHHS is using to report this measure at the AE-level (across MCOs).
- Updated the SQL code to attribute members to a single MCO and AE, based on the MCO and AE to which the member is attributed in the last month of the reporting period, respectively and to only include ED visits or member months for the months in which the member was attributed to that MCO.

Description

ED visits per 1,000 member months of adult members enrolled with an MCO and attributed to an AE who are identified as having experienced mental illness.

Eligible Population

Product lines	Medicaid
Ages	18 years or older as of December 31 of the measurement year
Continuous enrollment	None
Allowable gap	None
Anchor date	N/A
Lookback period	The measurement year and the two years preceding the measurement year (a rolling lookback period for total of 36 months)
Benefit	Medical
Event/diagnosis	Two or more visits with specific mental illness diagnoses. A 'visit' is defined as a unique member and date of service. See "Denominator" tab in Excel spreadsheet for eligible codes.
Exclusions	• Members in hospice care (see "Denominator Exclusions" tab in Excel spreadsheet for eligible codes)

Administrative Specifications

Denominator	The eligible population, reported in 1,000 member months[39]

[39] A member should be included in the measure due to a history of qualifying mental illness claims in the 36-month lookback period for the MCO with which they have coverage as of December 31st of the measurement year. Of

Numerator	Number of emergency department visits from the denominator (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit.[40] EOHHS is calculating the measure using the revenue codes associated with visits to the ED. See the "Numerator Option 1" tab in the Excel spreadsheet for eligible codes.[41]
Numerator Exclusions[42]	• ED visits that result in an inpatient stay. • Mental health and chemical dependency services. See "Numerator Exclusions" tab in Excel spreadsheet for eligible codes.

Excel Spreadsheet

ED Utilization for Individuals Experien

Oracle SQL Code Used by EOHHS

ED Utilization for Individuals Experien

note, if an MCO does not have 36 months of claims for the member, it should utilize all the claims it has for the member for up to 36 months for the lookback period (e.g., if an MCO only has 24 months of claims for a member, it should utilize all of the 24 months for the lookback period).

[40] When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the outpatient/ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An outpatient, ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

[41] While EOHHS is using "Numerator Option 1" to calculate performance for this measure, MCOs could also calculate the measure using codes associated with procedures that are commonly performed in an ED with an ED place of service code. See the "Numerator Option 2" tab in the Excel spreadsheet for eligible codes.

[42] Apply exclusions at the claim line level. Keep all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Appendix I: Potentially Avoidable ED Visits

Potentially Avoidable ED Visits
Steward: New York University, Modified by Rhode Island Executive Office of Health and Human Services
As of January 4, 2021

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- These are the specifications that EOHHS is using to report this measure at the AE-level (across MCOs).
- Updated the SQL code to attribute members to a single MCO and AE, based on the MCO and AE to which the member is attributed in the last month of the reporting period, respectively and to only include ED visits for the months in which the member was attributed to that MCO.

Numerator

The total sum of the probabilities of 1) preventable/avoidable emergent ED visits, 2) non-emergent ED visits, and 3) emergent ED visits that could have been avoided by regular primary care, using the probabilities supplied by NYU for the primary diagnosis code (ICD-9/10) of each ED visit. Only visits from Medicaid members should be included. There are no age or continuous enrollment exclusions.

Denominator

All ED visits for Medicaid members in the measurement period. There are no age or continuous enrollment exclusions.

Calculated: Preventable ED Visit Rate

The total potentially avoidable ED visits (numerator) divided by all ED visits, stratified by MCO and AE.

Additional Information

Additional Information on the NYU methodology, including a list of ICD-9/10 codes can be found here: https://wagner.nyu.edu/faculty/billings/nyued-background.

- Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3881233/.

Oracle SQL Code Used by EOHHS

Potentially Avoidable ED Visits I

Appendix J: Outcome Measure Reporting for PY3 Performance Improvement Plan Requirements and Templates

Submission Requirements

For Outcome Performance Year 3, AEs and MCO dyads must demonstrate *well-conceived, substantive and well-executed* effort to improve performance on three EOHHS-specified Outcome measures:

- All-Cause Readmissions
- Emergency Department Utilization for Individuals Experiencing Mental Illness
- Potentially Avoidable ED Visits

Performance improvement reports should be submitted to Debbie Morales (Deborah.Morales@ohhs.ri.gov). The performance improvement reports should describe activities that occurred during Outcome Performance Year 3, not efforts that occurred in the past. AEs and MCOs are expected to work together to complete required submissions and participate together in the interview with EOHHS. Each AE is encouraged to work with all of its MCOs together rather than separately. MCOs should provide technical support to AEs. While AEs and MCOs are not required to submit performance improvement plans, EOHHS will review such plans and provide feedback to any AE and MCO dyad that wishes to do so (or to an AE working with multiple MCOs on the plan).

Action	Deadline	AE Incentive Pool Allocation
Submission of Outcome performance improvement reports	12/31/2020	Up to 15%
Interview with EOHHS to discuss Outcome performance improvement efforts	2/15/2021	Up to 20%

Evaluation Criteria

Action	Evaluation Criteria
Performance Improvement Report	• Describe interventions that occurred during OPY3, and not interventions that occurred in prior years, although 2020 activities may build upon prior years' work. • Describe cause-and-effect analysis to define problem, problem definition, and PDSA cycle[43] to improve performance • Provide pre- and post-intervention performance on measures of success • Describe facilitators, barriers, and lessons learned from the intervention that could be applied by other organizations • Submission is timely with no extension request, and complete (response to all topics in the submission template, for all three Outcome measures)

[43] For a description of PDSA cycle elements, see: www.health.state.mn.us/communities/practice/resources/phqitoolbox/pdsa.html.

Action	Evaluation Criteria
Interview	• Confirmation that the performance improvement activity was well-conceived, substantive and well-executed for all three Outcome measure topics • Clear articulation of what the next intervention iteration could look like • ACO and MCO participants are in attendance • Interview completed on or before 2/15/21

Outcome Performance Year 3 - Performance Improvement Report Template

Contact Information

AE	
AE Contact Email Address	
MCO	
MCO Contact Email Address	

Measure: All-Cause Readmissions

#	Topic	Response
1	Identify current state of performance and future state goals/target	
2	Describe results of cause-and-effect analysis to identify factors driving performance	
3	Provide the problem statement resulting from the cause-and-effect analysis	
4	Describe the PDSA cycle, including the intervention activity that occurred in OPY3, and associated timelines	
5	Describe the AE's role in the project	
6	Describe MCO's role in the project	
7	Provide baseline and post-intervention data specific to the intervention and if goals were met for intervention group	
8	Describe why you think performance improved or did not improve based on your intervention	
9	Describe resources (personnel, infrastructure, and direct costs) used to conduct the improvement activity	
10	Describe lessons learned that may be applicable across AE and MCO dyads	
11	Describe plans for next iteration of performance improvement, and if intervention effective, how will the plan scale the work	

Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

#	Topic	Response
1	Identify current state of performance and future state goals/target	
2	Describe results of cause-and-effect analysis to identify factors driving performance	
3	Provide the problem statement resulting from the cause-and-effect analysis	
4	Describe the PDSA cycle, including the intervention activity that occurred in OPY3, and associated timelines	
5	Describe the AE's role in the project	
6	Describe MCO's role in the project	
7	Provide baseline and post-intervention data specific to the intervention and if goals were met for intervention group	
8	Describe why you think performance improved or did not improve based on your intervention	
9	Describe resources (personnel, infrastructure, and direct costs) used to conduct the improvement activity	
10	Describe lessons learned that may be applicable across AE and MCO dyads	
11	Describe plans for next iteration of performance improvement, and if intervention effective, how will the plan scale the work	

Measure: Potentially Avoidable ED Visits

#	Topic	Response
1	Identify current state of performance and future state goals/target	
2	Describe results of cause-and-effect analysis to identify factors driving performance, including understanding the effects of COVID-19 in reducing potentially avoidable ED visits.	
3	Provide the problem statement resulting from the cause-and-effect analysis	
4	Describe the PDSA cycle, including the intervention activity that occurred in OPY3, and associated timelines	
5	Describe the AE's role in the project	
6	Describe MCO's role in the project	
7	Provide baseline and post-intervention data specific to the intervention and if goals were met for intervention group	
8	Describe why you think performance improved or did not improve based on your intervention	
9	Describe resources (personnel, infrastructure, and direct costs) used to conduct the improvement activity	
10	Describe lessons learned that may be applicable across AE and MCO dyads	
11	Describe plans for next iteration of performance improvement, and if intervention effective, how will the plan scale the work	